Patient Acknowledgement and Consent
for Health Information Disclosure, Evaluation, Treatment, and Billing

1. I understand that Community Cancer Foundation, dba Community Cancer Center and OHSU Department of Radiation Medicine (referred to below as "this Practice") will use and disclose **health information** about me as described in the **Notice of Privacy Practices** provided to me. I have received a copy of the **Notice of Privacy Practices** and have reviewed and understand the information included in it.

2. I grant permission for the Community Cancer Center and it's providers to evaluate and/or treat the above named patient.

3. I authorize this Practice to obtain prescription history information through the Pharmacy Benefit Manager. This monitoring allows the Practice to receive all current prescriptions that you have been prescribed by any of your providers within the last 12 months

4. I authorize payment to be made to this Practice for services provided.

5. **Copays are due at the time of service.** As a courtesy, we will bill your primary, and one secondary, insurance. However, **payment will be expected in full from the patient within 30 days after the patient's responsibility has been determined**, unless other payment arrangements have been made. If the provider is PARTICIPATING with my insurance carrier, I am only responsible for deductibles, co-insurance, and any non-covered services. If the provider is NON-PARTICIPATING with my insurance carrier, I am responsible for my account in full. Those patients undergoing radiation therapy will have individual financial counseling during their treatment period with estimated patient responsibility presented.

By signing below, I agree that I have reviewed and understand the information above.

By: _____ Date: _____
(Patient Signature)

_____
(Printed Name)

-OR-

By: _____ Date: _____
(Patient Representative)

_____
(Printed Name)

Description of Representative's Authority: _____